MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

October 14, 2009
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) met on Wednesday, October 14, 2009 in Room 643 of the Legislative Office Building. Members present were Senator Martin Nesbitt, Co-Chair; Representative Verla Insko, Co-Chair; Senators Austin Allran, Bob Atwater, Doug Berger, Charlie Dannelly, James Forrester, Ellie Kinnaird, and William Purcell, and Representatives Martha Alexander, Jeff Barnhart, Beverly Earle, Bob England, Jean Farmer-Butterfield, Carolyn Justus, and Fred Steen. Advisory members Senator Larry Shaw, Representative Van Braxton and Representative William Brisson were also present.

Lisa Hollowell, Joyce Jones, Shawn Parker, Susan Barham, and Rennie Hobby provided staff support to the meeting. Staff Gann Watson and Ben Popkin listened to the meeting via real-time streaming audio through the NCGA intranet. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Senator Martin Nesbitt, Co-Chair, called the meeting to order and welcomed members and guests. Senator Nesbitt acknowledged and endorsed the advocates' efforts in seeking additional funds in the mental health system as recently recognized in the press. Representative Insko added that it was important for people to be involved from all concerned parties. She said that plans were underway preparing for the cut of stimulus dollars next year and that it was important to work together and look for efficiencies and a way to pull back. She also said she was appreciative of the Department efforts and the partnership that has been developed.

Secretary Lanier Cansler from the Department of Health and Human Services (DHHS) provided an update on the $1.5 B coming out of the healthcare system to try to accomplish the budget reductions required by the Legislature. He added that attempting to keep the system together while adjusting for the budget reductions is a difficult task. He explained the Department is moving away from independent "silos of care" towards a more coordinated system of care with better communication, making the system stronger, more streamlined and more efficient in order to improve the overall care of those receiving services. It is important to not duplicate services or provide services that are not clinically sound. Furthermore publically funded mental health services must have a clinical basis. The Secretary noted that all providers will be impacted and some services will have to change through imposing the reductions. To sustain itself the system will move towards the use of comprehensive providers or critical access behavioral health agencies that offer an array of services that are clinically founded led by properly trained clinicians, and some services will be provided only through a comprehensive provider, or

in affiliation with a comprehensive provider; other services will be available through an independent provider.

Shawn Parker, Legislative Analyst, explained that as directed in the money report, funding for high risk intervention Level III and IV group homes is to be reduced by $15.8M in FY 2009-2010 and $22.5M in FY 2010-2011. Based on budget estimates, the current program costs about $180M with the State share costing about $60M. The budget directed the establishment of a team inclusive of providers, LMEs, and other stakeholders to assure effective transition of recipients to appropriate treatment options.
The restructuring shall address all of the following:

- Submission of the therapeutic family service definition to CMS.
- Reexamination of entrance and continued stay criteria for all residential services.
- Require all existing residential providers or agencies to be nationally accredited within one year of enactment of this act.
- Length of stay is limited to no more than 120 days.

Specifically for Level III and IV group homes, before a child can be admitted for placement one or more of the following must apply:

- Placement is from a higher level placement such as psychiatric residential facility or inpatient
- Multi-systemic therapy or intensive in-home therapy has been unsuccessful
- The Child and Family Team has reviewed all other alternatives and recommends Level III or IV placement due to maintaining health and safety
- A transition or discharge plan is submitted as part of the request.
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Christina Carter, Implementation Manager with the Division of MHDDSAS reported on how the transition of the Level III and Level IV group homes is taking place across the State. (See Attachment No. 2) Ms. Carter's presentation focused on:

- The intricate role of the LME in transitioning children – triage, seeing that Best Practice is provided; Child and Family Team evaluate and insure System of Care principles are implemented; and complete evaluation of services in each catchment area within each LME.
- How Community Supports Qualified Professionals coordinate appropriate supports.
- A review of discharge plan criteria under Implementation No. 60 and No. 62.
- Ms. Carter indicated that most of 8 residential providers with 16 plus beds have decided to reduce or convert to PRTF; all 16 plus beds must be eliminated. She offered data which included the number of recipients in Level III and IV group homes; discharge percentages; types of referrals from Child Family Teams; and services that need to be expanded across the State and indicated that the outcomes were being tracked in a variety of ways to insure positive results.

Requests from committee members included a chart depicting the services offered verses those needed per county; request for the number of children that have returned home from a group home; information on PRTF – how many children per unit, what type of building and where they are located.

Committee members shared a great concern over downsizing and emphasized the need to follow up to see that children are taken care of and not going into the Department of Corrections. There was also concern over accountability and having the system of care coordinator track children as they move through the service array.

Ms. Carter was asked how North Carolina has such a disproportionate number of children (¼ of the national population) in Level III and Level IV facilities. She responded that she thought it was a historical problem – legislation, rules, policies, procedures, the way we think about care, moving people out of institutions, the models we have, the practices put in place, and financial incentives or disincentives in the system. Leza Wainwright, Director of the Division of MH/DD/SAS said that there had been the desire to find an alternative to the institutional level of care so the group homes were designed to be less intensive. The problem occurred when the rules and requirements were not that significant and the rates were attractive and more providers offered this level of care than was anticipated. As a result, alternative services that would have maintained children at home could not grow because the Level III providers had saturated the market.

Grace Crockett, Director of Mecklenburg Area Mental Health provided a presentation on how Local Management Entities were being impacted by the transition of child Level III and IV residential services. (See Attachment No. 3) She said that Mecklenburg County began 3 to 4 years ago moving children out of Level III homes and into therapeutic foster care or other services. The LME approached the transition with providers not as a financial issue but rather one of Best Practice. Mecklenburg currently has no Level IV homes and Level III beds have gone from a high of 579 to 166 beds and will likely continue to decline.

Lisa Hollowell from Fiscal Research told members that the upcoming report on Community Support was a follow-up to questions asked at the last meeting. She said there was a $65M reduction in the budget in the first year for Community Support and a greater amount in the second year. When the budget was put together members were told that the entire budget for Community Support was $640M. There were some inconsistencies with that information and what was presented last month. Ms. Hollowell said the Department would reconcile that information and address other concerns in their presentation today.

Leza Wainwright, Director of the Division of MH/DD/SAS, said she would respond to the programmatic concerns and Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, would respond to budgetary aspects as they are in DMA. Ms. Wainwright addressed what Community Support service does now, what the alternatives are, and how many alternative services are available in each catchment area. (See Attachment No. 4) Her presentation included:

- Review of case management functions and other services currently offered by Community Support for children and adults.
- Review of alternative services available based upon consumer's medical needs.
- Availability of alternative services chart based on providers who are billing for services.
- Piedmont operates under Medicaid waiver and directly enrolls their own providers; not necessarily enrolled in larger Medicaid program resulting in incomplete data.
- Case Management and Peer Support amendments are in final steps of preparation and will be sent to CMS shortly; effective date of Case Management anticipated to be January 1, 2010; Peer Support – July 1, 2010.

Tara Larson addressed the expenditures of Community Support as well as other mental health services within the Medicaid budget. (See Attachment No. 5) Her presentation provided:

- Review of historical expenditures from 2007 – 2010 YTD.
- Community Support is a Medicaid program and service must be provided so money may need to be moved from one part of Medicaid to another. A Medicaid service cannot be denied based on the lack of availability of funds.
- Transitioning can take place even with all the competing factors; clinically the array is in place to meet the needs of the consumer.
- $210M difference in budgeted funds from 2008 to 2009 and $166M difference from 2009 to 2010.
- More recipients served under Community Support in 2009 than in 2008. Number of providers stayed the same in some areas or decreased overall statewide as a result of not meeting some of the accreditation requirements.
- Recipient appeals – 1,800 – 2,000 people in the appeals process; being processed in the 90 day time frame. Most cases resolved in mediation process at OAH.

After lunch, Dr. Melissa Johnson representing Wake County Young Child Mental Health Collaborative and Mecklenburg Infant Mental Health Collaborative, (an interdisciplinary group supporting mental health efforts in children from birth to age five), addressed the Committee to request that the Committee consider recommending funding an Institute of Medicine study to determine needs statewide and suggest effective strategies for serving this age group. (See Attachment No. 6) An NC IOM study could focus on:

- Expanding the capacity of existing services to include professionals skilled in addressing needs of birth to five age group.
- Expanding existing services to include skilled professionals to work with this population.
- Reviewing types of children effected and needing services; data supporting needs of this population; kinds of services offered.

Members expressed interest in recommending that the IOM do a study. With the endorsement of the Committee, IOM could begin a study in June 2011. The Committee decided that the recommendation would be included in the next LOC report to the General Assembly.

Senator Nesbitt asked for a motion to approve the minutes from the last LOC meeting on September 23, 2009. The motion was made by Senator Purcell and the minutes were approved.

Leza Wainwright reported on the status of the CAP MR/DD Supports Waiver. (See Attachment No. 7) She provided a brief description of the Supports Waiver and said that the waiver was expected to serve nearly 1,000 people this year. Ms. Wainwright explained how Supports and Comprehensive Waivers are alike and how they are different. The current average annual benefit for the Comprehensive Waiver is $48,000. About 10,000 people are being served between the two waivers with 187 on the Tier 1 waiver and the remaining on the Comprehensive Waiver. A key service on the

Comprehensive Waiver but not offered under the Supports Waiver is residential support. MS. Wainwright explained that when the Comprehensive Waiver is broken up into 3 waivers, Tier 2 will offer self-directed services. She noted that the Department is writing an RFP for a financial management service agency to help participants with self-direction and community resource consultant, to advocate, guide, and assist participants will be selected through a RFP.

The Committee was interested in knowing how much the cost would be beyond the Supports Waiver at $17,500, for financial management services, for a community resource consultant and for case management. Ms. Wainwright was also asked to explain how the population currently being served would be distributed across Tiers 1-4. She replied that she would get the information for the members.

As an introduction to the Case Management presentation, Joyce Jones from the Bill Drafting Division said that the budget included a significant, recurring reduction in funds for Medicaid Case Management services in the amount of $41M in FY2009/2010 and $72.9M in FY2010/2011. She said there was not much discussion about this reduction in the Appropriations Subcommittee because this option was not provided by the Fiscal Research Division. The Department presented this option late in the budget process. The special provision on Case Management directs the Department to absorb this cut by developing a comprehensive plan for consolidating all case management services throughout the Medicaid program (other than HIV case management) by December 1, 2009. Ms. Jones said the Department was asked to address many specific issues related to implementation of a new consolidated Case Management system, including:

- Whether there are any additional purposes for Case Management consolidation, other than the originally stated purposes of eliminating duplication and reducing costs;
- The current status of Case Management duplication;
- Total Case Management Budget at this time, broken down by state and federal dollars;
- Projected rate changes;
- And very importantly, CCNC's role in this process.

Tara Larson reported on what has happened thus far regarding the consolidation of Case Management as directed by the General Assembly. (See Attachment No. 8) A Public forum has been held and a work group has been established to develop a plan of consolidation, including impact on other non-Medicaid reimbursable services. The work group has drafted proposals which have been distributed and posted to a website for feedback. Some major issues covered in the presentation include:

- An elimination of some of the administrative duties.
- Clear definitions for Case Management and Care Management to eliminate confusion.
- Review of expenditures of Case Management for SFY 2009.
- ICF-MR cannot bill for Case Management since it is part of the per diem.

- Results to changes in Case Management should create better outcomes in other health care and Medicaid services.
- Projected savings - $14 to $17 million – elimination from line items in Case Management.

Ms. Larson was asked to provide statistics on other states successes and failures regarding case management, the cost projections, and implications.

There being no further business, the meeting adjourned at 4:25 PM.

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Senator Martin Nesbitt, Co-Chair	Representative Verla Insko, Co-Chair

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Rennie Hobby, Committee Assistant